Leslie E. Barnes, Ph. D., LMFT
Licensed Psychologist
Licensed Marital and Family Therapist
3010 South Harvard, Suite 110
Tulsa, Oklahoma 74114
Phone: (918) 749-1840; FAX: (918) 749-1841

INFORMED CONSENT

I understand that Dr. Leslie Barnes has been retained to conduct a psychological evaluation of myself at the request of the OSU medical school and human resources department. This evaluation will consist of a clinical interview and written psychological testing. I understand that the results of this evaluation will be released in the form of a written report to the designated individual in the human resources department of the OSU medical school. I understand that the information obtained in this evaluation is under the primary control of the OSU medical school and that this psychologist is contracted with the medical school to provide the evaluation. The information obtained during the evaluation will be used to identify any recommendations that may be indicated and related to the issues of concerns which prompted this evaluation. Although recommendations based upon the evaluation may be made by Dr. Barnes, any decisions based upon evaluation data will be made by personnel of the OSU medical school.

Jeffrey Snyder
Jeffrey Snyder

6-12-14
Date

Dr. Leslie Barnes

6-12-14
Date

EXHIBIT
1

LESLIE E. BARNES, PH.D., LMFT
Licensed Psychologist and Licensed Marital and Family Therapist
3010 South Harvard, Suite 110
Tulsa, Oklahoma 74114
Phone: (918) 749-1840

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient Name: Jeffrey Snyder Birthdate: _____

I, the undersigned, authorize Dr. Leslie Barnes to communicate about the above-named patient with the following individual or agency by:

✓ providing information to: ✓ receiving information from:

Debby Nottingham — _____
Individual/Agency — Phone Number

OSU Med Ctr.
744 W. 9th Str. — _____
Address Tulsa 74127 — City, State, Zip Code

Information to be released by Dr. Barnes:	Information to be released to Dr. Barnes
____ Verbal communication	✓ Verbal communication
✓ Evaluation results and report	____ Medical/psychological records
____ Treatment summary	____ Treatment summary
____ Other_____	____ Other_____

I authorize the release/receipt of this information until: June 12, 2015

This authorization covers the release of information that may already be contained in Dr. Barnes' records as well as information to be collected during the course of my treatment/assessment with Dr. Barnes. This authorization is subject to my written revocation at any time, however, revocation does not cover any information that has already been released. I have a right to receive a copy of this authorization and a copy of this form is valid as the original.

My signature below indicates that I authorize the release/receipt of this information and understand the conditions for the use of the information as described above.

Jeffrey Snyder — _____
Printed name of person signing this form — Relationship to patient

Jeffrey Snyder — 6-12-14
Signature — Date

_____ — _____
Witness — Date